River Valley Neuropsychology, LLC

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Consent for Neuropsychological/Psychological Testing

Nature and Purpose of Assessment: I understand that my physician or other health care provider has requested this evaluation. The purpose of this evaluation is to provide information in order to assist with diagnosis and/or treatment. The material obtained from this evaluation (i.e., any records provided, interview(s), and psychological/neuropsychological testing) will result in the generation of a report that will provide information related to diagnosis and/or treatment. The results of this evaluation will be discussed with me if I desire, and if there are any other individuals whom I would like the findings of this evaluation to be shared, I can so designate by signing a release of information. If this evaluation is being covered or partially covered by my insurance, some information may need to be provided to the insurance company.

Foreseeable Risks, Discomforts, and Benefits: For some individuals, assessments can cause fatigue, frustration, and anxiousness. IN addition, certain questions may touch on personal and private matters that could cause me emotional discomfort. I recognize that there is no intention of causing any personal discomfort, but that this may be an unforeseeable risk associated with this evaluation. Furthermore, I understand that some of the questions or tasks may not appear at first glance to have a direct connection with this issue(s) at hand, but I will cooperate to the best of my ability. I understand that although I am expected to give honest and accurate answers, I am free to refuse to answer any question I choose or to terminate the evaluation whenever I wish. There are several benefits in undergoing this evaluation. Some examples include, but are not limited to, the following: clarification around diagnosis and treatment, identification of appropriate and relevant interventions and/or supports, documentation of improvement/decline over time or following treatment, and improved self-knowledge and awareness. Additional risk/benefits specific to my evaluation will be discussed in greater detail with the evaluating psychologist/neuropsychologist.

Time Commitment: Assessments may take several hours of face-to-face testing. The psychologist/neuropsychologist will also require additional hours for scoring, interpretation, and report preparation.

Limits of Confidentiality: Information obtained during this evaluation is confidential and can ordinarily be released only with my written permission. Additionally, we do not routinely provide copies of test data directly to patients or non-behavioral health treatment providers. There are some special circumstances wherein we will be permitted by law to disclose confidential information without your specific authorization, for example, if there is reason to believe that you may harm yourself or others, or if we have a reasonable belief that you have abused or harmed a child or elderly person, or if a court of law orders us to do so.

The terms of this informed consent have been reviewed, understood, and agreed to by me. I have had the opportunity to ask any questions and/or raise any concerns that I have regarding the evaluation process.

_____ _____
Signature of Patient/Legal Representative* Date

_____ _____
Witness Date

_____ _____
Interpreter responsible for explaining the assessment process (if applicable) Date

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.*